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PRINCIPAL INVESTIGATOR: Barbara F. Sharf, Ph.D.

CONTRACTING ORGANIZATION: University of Illinois at Chicago  
Chicago, Illinois 60612-7277

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B. F. Shaw  
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10/10/98  
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## Table of Contents

Introduction .....	pp 1-2
Body .....	pp 2-7
Assumptions & Methods .....	2-3
Results & Discussion .....	3-6
Revisions in Statement of Work .....	6-7
Conclusions .....	pp 7-8
References .....	pp 9-30
Books, journals, etc. ....	10-11
Magazines, 1965-75 .....	12-16
Newspapers, 1965-75 .....	17-23
Magazines, 1976-1985 .....	24-30
Appendix A .....	pp 31-34
Content categories .....	32
Table 1: Magazines by Category, 1965-75 .....	33
Table 2: Newspapers by Category, 1965-75 .....	34
Appendix B: Manuscript .....	pp 35-64
(The Emergence of Patient Choice: Breast Cancer in the Popular Media, 1965-1975)	



## Introduction

The creation of meaning through public communication is crucial to how people approach many serious health problems, with breast cancer serving as a paradigmatic instance. For example, whether or not women enact possible preventive measures such as diet or exercise, or routinely follow through on early detection procedures; what modes of treatment and coping people with breast cancer decide to follow; and to what degree this disease is prioritized in terms of public policy is greatly influenced by how individuals understand the disease and its impact on their lives (e.g., Gifford, 1986). In addition to the effects of public health campaigns and conversations with health care professionals, social constructions of breast cancer are shaped considerably by ideas conveyed in the popular mass media. In fact, everyday mass media messages provide a continuous context in which sociocultural meanings pertaining to breast cancer are embedded. Yet, despite the prevalence of breast cancer and the complex symbolic associations both with the breast and with cancer in American culture (Yalom, 1997), very few previous investigations of this topic exist (Lupton, 1994; Olive, 1996).<sup>1</sup>

The purpose of this study is to assess the ways in which popular mass media play a significant role in constructing the sociocultural meanings embedded in the public's understanding of breast cancer as a societal problem, a disease, and a personal illness experience. To accomplish this objective, this research project encompasses four phases which include: 1) an historical investigation of how breast cancer has been publicly depicted in popular print media over the thirty-year period of 1965-1995; 2) an analysis of how four current controversies regarding diagnosis, treatment, risk assessment, and genetic testing have been presented in popular print media over the past five years; 3) an examination of the implications of entertainment television having appropriated breast cancer as subject matter; and 4) a meta-analysis of the sociocultural impact of popular depictions of breast cancer in terms of individual citizen decision-making.

This annual report will describe work accomplished during the first year of this project, in which analytical work has focused on the first two decades of the historical investigation (1965-1985). From this analysis arises competing, often conflicting, themes of the portrayal of breast cancer as the disease most feared by women, the portrayal of breast cancer research as a war in which a steady stream of victories are claimed by medical science, public controversies within the medical profession, and the voices of women affected by this disease gradually demanding greater autonomy in making medical decisions that affect their lives. Also striking in this analysis is the realization of the degree to which cultural responses to breast cancer issues are the direct and indirect

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<sup>1</sup>Previous studies by this author have touched on the portrayal of cancer in various aspects of popular culture, including ovarian cancer on prime-time television (Sharf & Freimuth, 1993; Sharf et al., 1996), breast cancer as poster art (Sharf, 1995), as activism (Sharf, 1997a), and as Internet discussion (Sharf, 1997b).

results of many concurrent social and political events, including the war in Vietnam, politically-motivated attempts to win favor with public sentiment, women's liberation, and patients' rights. Finally, it becomes clear that the roots of some current issues, such as confusion over setting guidelines for mammography and risk assessment of cancer treatments and preventive measures, were evident a quarter century ago, and that the appeal of the metaphor of making war on cancer has not changed in over three decades.

## Body

### Assumptions & Methods

The underlying premise of this research is that how mass media construct breast cancer for the public---its most prominent themes, controversial issues, memorable dramas and stories, and possible courses of action---affects how individual citizens become aware of, comprehend, and make decisions about breast cancer-related matters. The study relies on the use of critical-interpretive analysis (Rabinow & Sullivan, 1987) of verbal content in order to answer questions of "what", "how", and "why." The interpretive aspect necessitates the centrality of the investigator's judgment, based on evidence grounded within the discursive materials being examined. The critical-interpretive process employed in this research includes four elements: identification of thematic categories and comparing the emphasis given within the array of categories at various time intervals in order to assess how topic emphases change over time; identification of major public narratives, images and metaphors, which help to translate abstract and difficult biomedical matters in personal terms that draw the public's attention, provide motives, and coalesce attitudes; identification of underlying value-based ideologies in order to explicate the moral premises and arguments implicit in these media accounts; and assessment of how media constructions of breast cancer may influence individual citizen choice and decision-making.

During this first year of research 492 magazine articles and newspaper articles have been reviewed (see References). Magazine articles were identified through the use of The Reader's Guide to Periodical Literature (on-line indexes of popular literature do not go back this far in time), looking under the general category of "cancer" from 1965 to 1974, at which point "breast cancer" was listed as a separate category.<sup>2</sup> Newspaper articles were identified through the indexes of the *New York Times* and the *Chicago Tribune*.<sup>3</sup> The process, as anticipated, has been painstaking and labor- and time-intensive. The principal investigator and the research assistant have personally read through each article identified, coding the article for content (for code definitions and periodicals by category, see Appendix A). In a majority of cases, notes were taken on the article (investigators

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<sup>2</sup> Because I felt there was no valid way of sampling content at this early stage, the investigators read all articles listed with the exception of a selected few articles in the magazine *Science* which I judged to be too technical for the lay reader to comprehend or have interest in.

<sup>3</sup> Originally, I had planned to also include the *Los Angeles Times* as part of this review, but this source has since been omitted, due to the volume of material being examined.

have been careful to separate their personal comments as readers from summaries of content and quoted material). In fewer instances, the entire article was copied because it would have been difficult to summarize all the content, the style of the writing, or to describe visual components. Several articles needed to be multiply-coded because of the range of subjects covered within them. When problems arose in how to code a particular piece, the issue was discussed by the investigators during weekly meetings in order to further clarify or add category definitions. Also discussed were apparent differences in emphases among news magazines, women's magazines, and other types of serials, as well as general differences between newspaper coverage and magazine journalism. When review of all articles was completed for the years 1965-1975, the two investigators exchanged notes in order to gain familiarity with the material they had not yet read and to compare coding. In a very few cases, differences arose about how to code a particular piece, and again these differences were discussed until a mutually satisfactory conclusion was reasoned through, a process I consider as integral to the interpretive process. After all articles had been reviewed and content-coded, I wrote a manuscript that describes and evaluates the media themes of this decade, supported by evidence drawn from the periodical material (see Appendix B). We are now about mid-way through the same process for the second decade, 1976-1985.

In addition to the procedures just described, there have been several points along the way in which I felt it necessary to check secondary materials, such as books written in that era, other publications by some of the notable personalities in the key breast cancer dramas of the era, and newly emerging scholarship that illuminated some aspects of this investigation. Such additional research aided me in better understanding the cultural context in which the primary media articles had appeared.

### **Results & Discussion**

*The rhetoric of scientific progress.* Revisiting the decade of 1965-1975 through popular periodicals was a surprisingly vivid experience of recollection. While breast cancer is not discussed frequently or in great detail until the latter half of this time period, general references to cancer set the stage for the small and large dramas that later were poised to play out for public consumption. Until the early seventies, much of what the public read were summaries provided to science writers from the American Cancer Society (ACS), and later the National Cancer Institute (NCI). These summaries emphasized advances in cancer research and treatment, and a positive orientation toward future accomplishments. Within this rhetoric of scientific progress, physicians and cancer researchers are portrayed in a narrative sense as (sometimes, god-like) heroes, taking positive action against the dreaded enemy of cancer, while women patients are typically passive victims, tangential to the main action of the stories being told. The language of this rhetoric is characterized by metaphors of solving mysteries and scientific control of wildly proliferating cells. There is also an unrelenting optimism in the language of the ACS, holding out hope that if people take the widely advertised precautions of recognizing suspect symptoms and going to their physicians in a timely manner, breast cancer is a very curable disease. This position subtly

shifted responsibility to patients, while contradicting repeated descriptions of breast cancer as the most deadly disease afflicting American women, and flying in the face of less optimistic research reports from other sources (Greenberg, 1975).

***The politics of cancer.*** In addition to claims of scientific progress, cancer research also became a political target. This decade covered the time period in which the United States was involved in the unpopular war in Vietnam. Thus, it was not a coincidence when President Nixon declared war on cancer, perhaps as a diversionary tactic to embrace a struggle about which few people would oppose. His plan to step up biomedical research efforts in order to eradicate cancer was challenged by a rival Congressional plan, introduced by Senators Kennedy and Javits. Though war metaphors have long been commonly used within medicine, and previously had been specifically applied to cancer (Reagan, 1997), this form of figurative language became ubiquitous during this time period, while increased funding and political focus, brought cancer into the forefront of public attention. However, along with the benefits of such attention, also came increased scrutiny as to lack of improvement, especially in mortality rates, with breast cancer noted among these.

***The social context of breast cancer.*** A number of threads within the social fabric of the U.S. underwent significant upheavals during this time period. Three discrete but overlapping components especially paved the way for new discourses about breast cancer. First were advancements for informed consent and patients' rights. As a result of several court decisions, the formation of medical ethics guidelines, and increased consumerism within health care, it became accepted doctrine that patients have an explicit say in the decisions about medical treatments which physicians might wish to use with them. Second, so-called women's liberation or the women's movement, which had begun a decade earlier, was coming into full prominence, with women no longer to accept a passive role in all phases of life affecting them. Third, there began to appear personal narratives of women telling their stories of living with breast cancer, first in women's magazines, then in books and other sources; such narratives were in striking contrast to the stigmatized silence previously surrounding this subject. What these three changes had in common was helping to give voice to societal groups that had traditionally been silent; they were also three groups having a stake in how issues related to breast cancer should proceed.

***The rhetoric of choice.*** There was also a controversy brewing in the early seventies within the medical profession about how best to treat breast cancer. George Crile, a breast surgeon at Roswell Park Medical Center in upstate New York had been practicing breast conserving surgery for more than a decade, and believed he had evidence that his patients fared as well or better than those receiving the standard treatment of radical mastectomy. Though many viewed Crile as unorthodox, he was joined in his opinion by more favorably recognized surgeons, Oliver Cope and William Nolan. Interestingly, all three chose to take their case directly to laypersons by publishing in mainstream women's magazines and in newspapers. Later, there were additional articles from women who had heeded their advice and selected more conservative surgery, including well known



personality, Shirley Temple Black. Thus began a four year conflict among physicians, which became quite public, and raised societal-wide questions about the role of properly informed women patients in choosing the treatment they felt was in their best interest.

**Media role models.** While Shirley Temple Black was probably the first very well known woman to come forward with her own story of having breast cancer, at the end of this decade two events occurred which put this disease squarely on the front page of every newspaper in the country. The diagnosis of breast malignancies in First Lady Betty Ford, and one month later in Second Lady Happy Rockefeller shocked the country and underscored the prevalence of this disease. Betty Ford's decision to go public with the news of her diagnosis and subsequent radical mastectomy received a great deal of praise, and served as a public health education message that raised awareness and motivated thousands of women to have mammograms. Both Betty and Happy were treated as heroines and role models. Oddly enough, despite the discussions about women's choices in health decision-making that had gone on during the years previous to the crises of these widely recognized women, the patient behavior modeled by both women was that of a compliant patient, content to leave all decision-making up to their physicians. Furthermore, despite the fact that the results of the first NIH studies casting doubt upon the superiority of radical mastectomy as the standard treatment were known at the time of Betty Ford's hospitalization, consideration of alternative, more breast conserving treatments was not part of the narratives relayed by either of these prominent women. In the most public and dramatic breast cancer narratives of this decade, patient choice seemed not to be an issue. However, a few months later, another survivor of breast cancer decided to take a different stance. Rose Kushner, a journalist, researched her own disease, and became the first dedicated breast cancer activist, part of whose mission was to educate women so they could better think through the decisions that might befall them.

**Evolution into the eighties.** While my review of all the material covering the decade of 1976-1985 is not yet complete, enough has been done to describe characteristic trends of this time period. Reports of scientific progress continue with interest focused on improved results of using combinations of chemotherapy as adjuvant treatment to surgery. Gone, however, are the narratives featuring heroic physicians and scientists. Instead there are increased numbers of stories about women survivors, many featuring coping strategies and personal reflections on the challenges of living with this illness (e.g., Rollin, 1976). The discussion of which treatment may be most appropriate goes on, with women's magazines now carrying detailed descriptions of various forms of breast excisions and reconstructions. Of particular interest is the debate about lumpectomy versus modified mastectomy, a question still active to date. To keep such educational efforts upbeat, articles about breast cancer are often made part of larger sections about "breast health" along with information about diet, sexuality, breast feeding, breast augmentation, and even breast cosmetics. Such articles and special features are frequently framed as "good news" about breast cancer. While this decade lacks the major dramatic events of the previous ten years, it is worth noting four observations, encompassing subtle shifts taking place. The first is the move from patient choice to *patient responsibility* such that laypersons are increasingly held accountable for the management of detection and the consequences of

treatment selection, as well as decision-making in the face of uncertainty. There is also a steadily increasing *critique of medicine* (i.e., individual doctors, the direction of cancer research, and the medical establishment), diminishing the former reverential tone accorded to physicians and scientists in the popular press. Third, there is evidence of *increased formation of self-help organizations*, such that women are making use of their own hard-earned experience to help others, and are acknowledging their own expertise, in addition to making use of professional assistance. Finally, in the mid-eighties there appears to be a *decrease in attention being paid to breast cancer* as a social and medical problem. Interestingly, this is concurrent with the period in which HIV-AIDS gains recognition by the public, suggesting that the press chooses not to focus on two health crises concurrently.

### Revisions in Statement of Work

I am about midway through the historical analysis, whereas I had planned to be finished according to my original schedule. Reasons for my delay include the following: 1) It is taking about twice as long to read through and annotate the source material as I had anticipated. The pace has been consistent for both myself and the research assistant. 2) I have been surprised to feel the need to read a greater number of pertinent secondary source materials than I had anticipated. I believe this is because I am finding a broader cultural context much more applicable to my analysis than I could have known at the time I wrote my proposal. For example, I had not foreseen reading books on the evolution of the women's movement or verifying the timing of the Tet offensive during the Vietnam War. Despite the extra time and effort involved, I believe that going beyond the narrowly focused boundaries of breast cancer readings has yielded a much richer and more meaningful kind of analysis. 3) Most disruptive and unanticipated is the fact that I have changed jobs, moving to an institution in an entirely different geographic location, even though the grant and my work on it remains as part of my faculty appointment with the University of Illinois in Chicago. Both the complicated negotiations prior to the change of position, as well as the move itself did take some valuable time away from this project. Having re-located, and in continuous contact with the research assistant in Chicago, I am trying hard to make up for time lost.

Though I have completed one manuscript as foreseen in the original schedule (Appendix B), I originally had thought that one paper would encompass and summarize the entire historical overview. However, given the amount of detail included in this first paper, I now think it necessary that additional manuscripts will need to be written for the other parts of the history section; there is too much content to put it all in one paper. I don't see this as a problem. It simply means that this study is yielding more, both in terms of quantity and significance, than I had envisioned. This first paper was presented at a nationally attended conference in Chicago last spring and an enlarged version will be submitted to the Health Communication Division of the International Communication Association for a conference to be held in spring 1999. However, I have not submitted

the work for publication in a journal because I think it more suitable as a chapter for the book project that is planned in conjunction with this research.

In order to make maximum use of the research assistant during this second (and her final) year, I will assign more of her time to identifying and retrieving source materials needed for the other components of this investigation, so they will be available to me as I continue this work into year three.

### Conclusions

Two previous examinations of how breast cancer has been represented in the popular press, not surprisingly, reiterate some of the findings of this report. Olive (1996) emphasizes patterns that glorify medical prowess, as well as convey confusingly contradictory messages. Lupton (1994) critiques the degree to which discourse on breast cancer indulges in blaming the victim, and holds women responsible via life-style, personality, etc., for the disease that threatens them. While this investigation concurs with those assessments, it also highlights a more proactive tendency. Popular media have reflected, incited, and reinforced a move toward autonomy and choice among patients, away from passivity and unquestioning compliance. "Women's magazines" have played an especially pivotal role in this regard, not only in a politically progressive publication like *Ms*, but also in more traditional outlets like *McCall's*. It is fair to note that reforms in treatment, as well as in the conceptualization of the patient's role originated with both concerned male physicians, as well as outspoken women patients

However, informed consent, autonomy and choice turn out to be double-edged swords, and carry with them the weight of self-responsibility and risk assessment. This is an important turn in an era in which medicine is increasingly criticized and medical uncertainty more apparent. In the early days of mass screening through mammography, the NIH presented information to the public regarding concerns about exposure to radiation versus the virtues of early detection, and then asked women to make their own decisions as to whether to make use of this technology (and for a variety of reasons, it has been a struggle ever since to persuade women to come in for regular mammograms). This history is a precursor of contemporary analogues. Should healthy women take a chance on the possibility of uterine cancer and blood clots in exchange for possible protection against developing breast cancer by taking tamoxifen is a query taken out of today's headlines.

The importance of the research completed, then, is to enable us to look back in order to understand the origins of patient empowerment and activism, as well as to look forward to the present and future in terms of how the public may respond to mixed and contradictory expert advice on health issues. The project also clarifies the ways in which the larger culture imbues matters of disease and illness with symbolic and functional meaning, coloring the public's understanding and responses to a major health problem. In 1970, the war on cancer was in many ways an extension of the US's war in Vietnam (and has been

mentioned on the political agenda again this year, along with patients' rights). In 1998, approaches to cancer treatment may be intermingled with bureaucratic guidelines for managed care, and breast cancer research may be understood as much as a political entity as a scientific one, in part dependent on the status of defense spending and the ability to compete among a variety of disease-centered lobbies. These are, of course, early, and somewhat premature, findings, which will be further, developed in the work to come.



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**APPENDIX A**

### Content Categories

**BSR Basic Science Research:** reports on laboratory-based research, including cellular activity, viruses, rat & other animal experiments. Also, includes discussions of hypotheses about the possible causes and risk factors of bc.

**G Genetics:** research, therapy, testing & counseling related to genes & BC [reasoning used here. This begins as BSR, but becomes much more inclusive. Identification of BC gene a major scientific discovery in itself.]

**D Detection:** relates to the identification of breast cancer cells in living humans. Includes writing on the importance of early detection (sometimes referred to as "prevention"), as well as explanations, descriptions of diagnostic technologies, e.g., xerography, mammography, thermography, blood tests, BSE. [reasoning here. "Detection" is a more inclusive word than "diagnosis." For example, a recurrence may be detected.]

**T Treatment:** "Objective" (non-narrative?) descriptions of mainstream, biomedical therapeutic procedures, e.g., mastectomy and other surgeries, chemotherapy, radiation. Also includes experimental treatments, clinical trials (comparison among treatments, under scientific scrutiny).

**AT Alternative Treatment:** Therapeutic modalities practiced outside of mainstream, allopathic medicine (e.g., laetrile, variety of pain control techniques).

**E Epidemiology:** Prevalence or impact of bc on particular sectors of the population, e.g., racial, geographic. Includes environmental.

**C Coping:** Descriptions of how individuals have dealt with the problems associated with being diagnosed and ill with bc, and its treatments. Includes most personal narratives (not only people with cancer, but also partners & additional significant others).

**P Politics:** Association of bc with political candidates, leaders and party platforms. How decisions made on funding bc research and deciding on funding priorities.

**PC Patient Choice:** Discussions related to shifting power relations between the medical community and patients regarding treatment decisions. Includes capabilities of patients to exercise autonomous decisions and partnerships with doctors.

**PR Public Response:** Public registering its views about major news events, public figures, media representations related to bc. Issues may include tastefulness regarding privacy/publicity, how public reacts to controversies (eg, surgeries, when to get mammographies).

**PS Psychosocial Factors:** Connection of personality and mood with breast cancer. Explanations of impact of breast cancer on individual and family dynamics.

**PV Prevention:** Eliminating conditions that put people at higher risk for cancer including specific recommendations for diet and exercise



**Table 1**  
**Magazines by Category,**  
**1965-1975**

	<b>BRS</b>	<b>D</b>	<b>T</b>	<b>AT</b>	<b>G</b>	<b>E</b>	<b>C</b>	<b>P</b>	<b>PC</b>	<b>PS</b>	<b>PR</b>	<b>PV</b>
Miscellaneous	1	5	5	1	0	4	3	6	5	2	0	0
Women's	0	9	2	1	0	0	9	0	9	1	1	0
News	15	8	13	0	0	6	11	2	2	1	5	1
Total	16	22	20	2	0	10	23	8	16	4	6	1
N=128												

**Key to magazines:**

**Women's:** Better Homes & Gardens, Good Housekeeping, Ladies Home Journal, Mademoiselle, McCall's, , Ms., Redbook, Vogue

**News:** Newsweek, Time, US News & World Report

**Miscellaneous:** Ebony, Esquire, Nation, New York Times Magazine, Reader's Digest, Saturday Evening Post, Science Newsletter, Science Digest, Today's Health

**Table 2**  
**Newspapers by Category**  
**1965-1975**

	<b>BRS</b>	<b>G</b>	<b>D</b>	<b>T</b>	<b>AT</b>	<b>E</b>	<b>C</b>	<b>P</b>	<b>PR</b>	<b>PS</b>	<b>PC</b>	<b>PV</b>
<b>The New York Times</b>	30	1	35	16	0	5	9	1	0	9	9	0
<b>Chicago Tribune (1972-75<sup>4</sup>)</b>	8	0	20	19	1	5	11	3	8	2	9	1
<b>Newspaper Totals</b>	38	1	55	35	1	10	20	4	8	11	18	1
<b>N= 202</b>												

<sup>4</sup> Index for this newspaper does not begin until 1972.

**APPENDIX B**

**The Emergence of Patient Choice:  
Breast Cancer in the Popular Media, 1965-1975**

**Barbara F. Sharf  
Department of Medical Education  
University of Illinois at Chicago  
and  
Department of Speech-Communication  
Texas A & M University**

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### Foreword

The work presented in this paper is the first portion of a larger project. This project entitled *The Social Construction of Breast Cancer and Mass Media and Its Influence on Public Understanding and Citizen Decision-Making* is funded through the Department of Defense breast cancer research program, which has made possible the undertaking of many innovative investigations. I am particularly grateful that this work, grounded in the traditions of humanities scholarship (i.e., cultural studies and rhetorical analysis), rather than a basis of clinical science, public health, or behavioral science which are the usual targets of cancer funding, was chosen for support.

The overall objective of this study is to describe and comment upon the ways in which breast cancer has been socially constructed in public discourse, specifically in popular magazines, newspapers, and entertainment television over the last three decades (approximately 1965-95). Within this time period, breast cancer as a topic of social discourse has progressed from a subject that was considered embarrassing, stigmatizing, or pitiable, to one that has become highly visible, political, and nearly ubiquitous. Also during this era, the prevalence of breast cancer as a disease has grown to an all-time high; the mortality rate, which had been constant for several decades, has decreased slightly; funding for breast cancer research has more than quadrupled; and, most recently, scientific accomplishments such as the identification of breast cancer-related genes and the possibility of preventive chemotherapy focus attention on progress made and promise for what is to come. The premise behind this undertaking is that how mass media constructs breast cancer for the public---its most prominent themes, controversial issues, memorable dramas and stories, and possible courses of action---affects how individual citizens become aware of, understand, and make decisions about breast cancer-related matters.

There are three main parts to this investigation. The first is an overview of how breast cancer has been depicted in popular magazines and selected newspapers for the thirty-year period indicated. The second is an in-depth inquiry into how four separate controversies (i.e., breast cancer-related problems to which scientific medicine cannot offer a definitive solution) frequently faced by certain groups of women are represented in the media. The four controversies I have chosen include: the efficacy of mammography for women under fifty, the utility of genetic testing, decisions about taking hormone replacement therapy, and the efficacy of cell stem transplant therapy for women with the disease. The third part is an analysis of entertainment programming and television that has incorporated breast cancer. Throughout this study, I am interested in bringing to light which ideas and stories have been emphasized, which have been ignored, and the progression or changes in ideas over time; how confusion may result from conflicting information; and ways in which the public may be persuaded to affirm one perspective over other possibilities. As a final step I will assess this evolving discourse of breast cancer as a rhetoric directed primarily toward women, and its implications for other health-related public communication.

As a starting point, this paper takes us back nearly thirty-five years to a crucial decade in which breast cancer came out of the closet into public conversation, and women's voices became a prominent force in the discussion.

### **Introduction**

In 1965, breast cancer wasn't much talked about, especially as a topic of social conversation or a subject within popular culture.<sup>i</sup> To try to find magazine articles about breast cancer in *The Reader's Guide to Periodic Literature*, one would have needed to check under the general category of "cancer."<sup>ii</sup> Most of the articles within this category either referred to cancer as a single entity or provided information about specific kinds of cancer (although breast cancer was not prominently featured). However as the decade of

1965 through 1975 unfolded, a confluence of forces---medical, political, and social---brought cancer in general, and breast cancer in particular, into public focus. Based on a review of popular periodicals published during this time period,<sup>iii</sup> the following analysis describes how the socially constructed discourse about breast cancer was at once reflective of the surrounding culture and, conversely, a social influence as well. As will be demonstrated in what follows, the over-riding, lasting accomplishment of this public communication was its emphasis on patient autonomy and individual choice-making regarding cancer treatment.

### **Messages from Medicine: The Rhetoric of Scientific Progress**

During the latter half of the sixties, and into the early seventies, the public was exposed to a continuous stream of announcements about new advances and potential breakthroughs in cancer research, especially in newspapers and news magazines. The dramatic scenario of scientific progress was rooted in the laboratories of "the quiet, patient and painstaking men whose researches into the mystery of life itself may one day solve the deathly riddle of the cancer cell that lurks there" (The War on Cancer, 1971, p. 84). Typically, such stories were accompanied by photos of their protagonists, inevitably intense white men in lab coats, peering at test tubes, microscopes, or slides of malignant cells. Their work was depicted as "... the steady, dedicated and sometimes painfully slow attack by medical scientists against one of man's greatest enemies" (Schmeck, 1965, p. 17). A prime example was a 1973 *Time* cover story (Toward Cancer Control, 1973) about immunologist Dr. Robert Gold. Entitled "Toward the Control of Cancer," it features Gold as a self-described "operator" (p. 64), "who sees immunology as the key to understanding---and ultimately controlling---almost all diseases that afflict man" (p. 65). Such hyperbolic language, along with a striking, almost surreal photograph of the scientist "silhouetted against slide cell" seemed to imbue this man with heroic, even god-like, power.

A few of the scientific studies reported were, in retrospect, of transitory, even bizarre, interest, such as the experiment to heat up the blood of patients with advanced disease to 110 degrees Fahrenheit in order to "boil out" the cancer (Heat on Cancer, 1967); the research that showed "nuns are found more susceptible to some cancers," including breast (Brody, 1969, 16); or the comparison of wet and dry earwax to determine a possible genetic basis for breast cancer (Altman, 1973). More sustained topics that received particular emphasis during this time period included: explorations of who was at higher risk for getting cancer (e.g., personality traits, racial groups); fledgling attention to environmental and life style risks; the new detection technologies, such as mammography and thermography; new drug treatment possibilities; debates about so-called fraudulent treatments, like laetrile; and investigations into possible causes of the disease, such as immune disorders, viruses, and exposure to estrogens. Information about warning signs, how to do breast self-exams, and the need for annual medical examinations was widely disseminated, within numerous articles on the importance of early detection. However, this advice was offered with a caveat: "[This information] is intended to help you know more about your breasts, but not to help you make judgments about your health. Leave that to your doctor" (Ramsey, 1969, p. 82).

Metaphorically, cancer was a puzzle to be solved, "the most intensively studied yet least understood destroyer of life," (Zimmerman, 1967, p. 118) or the dreaded enemy to be fought and conquered. Breast cancer, specifically, was regularly introduced in popular press articles as the disease women fear most, and the biggest killer of women in the 35 to 55 age bracket, and "the disease that every woman fears" (Sandberg, 1974, p. 63). Even if readers had not previously thought much about breast cancer before reading such articles, the repeated pessimistic messages must have had a frightening impact on the public's awareness and perception. "[It] has always been one of the most intractable of malignancies, and few doctors see sudden improvement" (Greer, 1965, p. 32). "Cancer of the breast kills more American women than any other form of cancer" (What women don't



know . . . , 1974, p. 264). "For the last sixty years, doctors have been puzzled because the five-year survival rate for breast cancer has not improved" (Kotulak, 1972, 1: 16).

Because breast cancer diagnosis seemed inevitably linked to mastectomy, "the operation all women fear" (Nolan, 1971, p. 52) and "few women wish to talk about" (Black, 1973, p. 82), there were also numerous references to the consequence of losing a breast.

"Perhaps no diagnosis is more feared by women; many feel the price of saving their lives is their femininity" (Fighting breast cancer, 1972, p.103).

Somewhat contradictory, much more optimistic information was also used extensively to describe breast cancer: "It's the most curable of all leading causes of death: (Switzer, 1974, p. 138) and "the survival rate for this surgery always has been quite high" (Levine, 1973, 2:10). Typically, these upbeat messages came from the American Cancer Society (ACS), linked with the idea that if only people took actions that resulted in the early detection of breast cancer, such as annual medical examinations and monthly breast self-examinations, cure rates would soar. Characteristic of this tendency is a quote from Dr. Murray M. Copeland, president of the ACS in 1965: "The war is far from won, but the tide appears to be turning" (Rising hope, 1965, p. 55). This claim became much stronger over time; Dr. Arthur G. James, president of the ACS in 1973, stated: "I believe there is enough knowledge about cancer that if it were all properly utilized, we could render cancer a rather insignificant disease even today" (Kotulak, 1973, 1:2). Similarly, an ACS thirty minute public service film shown on television declared that if breast cancer is detected before it becomes a lump, "the cure rate approaches 100%" (Brody, 1973, 9:1).

x. And Dr. Justin L. Stein, president of the ACS in 1974, proclaimed: "There is no such thing as an incurable or terminal patient. There are people with advanced disease with poor prognoses, but there is always something that can be done" (Kotulak, 1974, 1:4).

Holding out hope to the public makes sense as a rhetorical strategy for the ACS. It is an organization that wishes to promote widespread participation in early detection by not scaring people away with unmitigated negativism. The promise of progress also is a

means toward fund-raising. A third consequence of this tactic is that it subtly shifts responsibility from the medical science enterprise to individual consumers. "It's the one major illness in which you alone can influence the outcome to a great degree," stated a spokesperson for the ACS (Switzer, 1974, p. 138).

However, several problems accompanied this discursive vision of breast cancer. One issue had to do with the language. "Prevention" was frequently employed erroneously in lieu of "detection" (as in the establishment of so-called cancer prevention centers [Steinberg, 1965]). The word "cure" in the popular media context could easily have been a source of misunderstanding for many readers since the American Cancer Society, the National Cancer Institute, and other cancer specialists defined that term as surviving five years past diagnosis, rather than longer-term survival; the families of people who died of cancer six years past diagnosis would hardly have considered their loved ones to be cured.

Further adding to the confusion was the publication of data from other credible sources that appeared to conflict with this unbridled optimism. For instance, a study conducted at Northwestern University indicated that "a high percentage of stage one and two cancers were not really localized as doctors had thought," but had spread to other parts of the body (Kotulak, 1972, 1:16), thus casting doubt on the ACS's whole-hearted confidence in the power of early detection. The World Health Organization found that, despite efforts made toward early detection of breast cancer, "more women than ever are dying from it," especially in North America and western Europe (More women die, 1975, 21:1). Science watchdog and scholar Daniel S. Greenberg (1975) published an academic critique, taking the popular press to task for not examining more carefully the uplifting messages of progress in cancer treatment that the ACS provided in its periodic updates to science writers, as well as information from the National Cancer Institute (NCI). In regard to breast cancer, he noted that the five-year survival rate had only increased from 60% to 64% between 1950 and 1975. In turn, Greenberg's criticism was picked up by

*Chicago Tribune* editorial commentator Nicholas Von Hoffman (1975, 2:14) who called the ACS "those master manipulators of terror and hope" and claimed that "people are getting suspicious of the cancer industry."

The rhetoric of scientific progress was, in essence, a popular distillation of work being done by cancer researchers. It is important to note that within these narratives of scientific prowess, in contrast to the hero scientist or clinician, and cancer as the challenging villain, patients were minor, largely undeveloped characters. When mentioned at all, they tended to be treated as props or part of the scene upon which the drama of scientific progress was being carried out. Some of the medical language quoted in these articles such as the ten-year "salvage" rate (Nobile, 1973, p. 210) further depersonalized the patient into an abstract statistic and disposable object. Exaggeratedly optimistic or alarming headlines by science writers ("Breast and Uterine Cancers: Guard Against the Women Killers!" [Kotulak, 1972b, 5:1]; "Rising Hope in War on Cancer" [1965]; "A Formula for Beating Cancer" [Steinberg, 1965]), drawn from upbeat messages from the ACS and NCI who briefed the press on a constant flow of investigatory studies set the stage for the perception that knowledge about what causes cancer and how best to treat it was increasing, with promising results. As the decade proceeded, however, along with the positive publicity came stinging criticism and public awareness of conflicting reports.

### **The Politics of Cancer: The Rhetoric of Making War on Malignancy**

It is traditional within medicine to conceive of the physician doing battle with disease; thus military metaphors have long been used to describe medical undertakings, and, as Sontag (1978) has pointed out, especially in regard to cancer. With the increased prevalence and publicity surrounding cancer as a public health problem during the decade of 1965-1975, the figurative language of war on cancer was further developed and ubiquitously employed. For example, physicians and basic science researchers were alluded to as "combatants" (The war on cancer, 1971, p. 84), treatment modalities were "weapons" (New aid, 1974, p. 65), the NCI looked for ways to "conquer" cancer (Rising

hope, 1965, p. 55), press updates from the ACS were called "battle reports" (Cancer, 1970, p. 55), and progress in this "struggle" came "after attacks on numerous fronts" (Greer, 1965, pp. 32, 108). Since 1935, the ACS (originally called the American Society for the Control of Cancer) had organized the "Women's Field Army" to educate others about cancer and women's health at a community level (Reagan, 1997). Thirty years later, they were described in this way: "In every one of the fifty states, volunteer armies of citizens, banded together into local units of the ACS, are winning real victories in the war against cancer using tactics your own town might copy (Greer, 1966).<sup>iv</sup>

In this same time period, there was an actual military battle ongoing. During the late sixties, the unpopular war in Viet Nam had escalated, complete with in-depth television news coverage and regular body counts (not unlike the repeated grim cancer mortality statistics). Following the unsuccessful 1967 Tet offensive, it had become depressingly clear to many in the American public that Viet Nam was a war that this country could not win and which was being fought at a terrible cost. Anti-war demonstrations created great dissension within U.S. society, with "doves" pitted against "hawks." In the midst of such upheaval, it is not surprising that the country's political leaders searched for a common enemy, a war that could be won and which no one could oppose on moral grounds. It was in this context that President Richard Nixon officially declared war on cancer as national policy in February, 1971 with a "massive commitment of public funds" (The war on cancer, 1971, p. 84). Interestingly, the focus on finding a cancer "cure" arose from a power struggle between Nixon and one of his main political rivals, Senator Ted Kennedy. The Nixon and Kennedy plans differed in terms of reporting authority structure and money allotments (at one hundred million dollars, Nixon's program fell far short of the Kennedy proposal, but still increased the cancer funding a great deal). Both men used analogies with other major projects that had been accomplished through focused funding and motivation. The Kennedy-Javits bill called for the creation of an "agency . . . modeled along the lines of NASA which succeeded so

brilliantly in reaching our goal of landing a man on the moon" (Silver, 1971, p. 110). In Nixon's State of the Union address, he said "... the same kind of concentrated effort that split the atom and took man to the moon should be turned towards conquering this dread disease" (The war on cancer, 1971, p. 84). The comparisons with the Manhattan Project and the Apollo moonshot also imply the search for a cancer cure was a competitive venture of which Americans would be proud. The Nixon proposal won the day, but not the war.

Despite lofty ideals to which both men tried to appeal, the political assault on cancer drew a good deal of criticism, regarding disease-targeted funding, pork barrel funding for a limited few researchers, the eventual unwillingness of the Nixon Administration to spend all the money that had been allotted, and other problems. The continued comparison with the Viet Nam War became more explicit as time went on. In a strange adaptation of language, one physician spoke of virus-like particles in a "de-militarized zone" between the cancerous and benign areas in human tissue (Altman, 1974, 14). One political commentator noted that the war approach was "one we Americans cotton to . . . . Surgery, radiation, chemical warfare all are aggressive, intrusive and powerful, just the stuff to knock out tough enemies like the Viet Cong or a cancer cell" (von Hoffman, 1975, 2:3).

Politicizing the war on cancer had the effect of strengthening the NCI as the arbiter of the breast cancer research that followed, increasing the amount and quality of that research, and raising the expectations and awareness of American citizens on this issue. At the same time, this framing of the problem drew attention to the fact that, despite ever-increased funding, the war on cancer was having as little success as the war in Southeast Asia had. As Daniel Greenberg (1975, p. 40) observed, there were "doleful similarities," including the "exaggerated hopes drawn from limited victories, . . . forecasts of a long, hard, fight, beyond which shines light at the end of the tunnel," as well as casualties without the achievement of intended results.

### **The Social Context: Giving a Voice to the Silent**

By all accounts, the late sixties and early seventies constituted a period of great social upheaval and activism. In addition to the influence of the war in Viet Nam, several other forces in society---legal, ethical, and feminist---were coming to bear in shaping the decade, including the cultural construction of breast cancer. As a result, two groups that previously had been relatively silent, patients and women, created ways that helped them to voice their respective concerns and choices. This social context set the stage for the controversy about patient choice in breast cancer treatment that arose concurrently.

***Informed Consent and Patients' Rights.*** For centuries, medical care was administered under the ethical principles of physician benevolence and non-malevolence, "Above all, first do no harm." Within this moral framework, doctors made decisions on behalf of their patients, without any compulsion to ask those patients how they would like to be treated. Since the early twentieth century, a series of court cases has gradually constructed a new ethical principal that may work in conjunction with physician benevolence, but also goes beyond it. This is the dual doctrine of patient autonomy and informed consent. The first precedent-setting cases<sup>v</sup> involved legal complaints by patients who had not given permission for the specific kinds of surgeries performed upon them. The court decisions in these cases re-affirmed the citizen-patient's right to be free from offensive or uninvited contact, i.e., assault (Katz, 1984). However, it was not until the late fifties that courts began to consider questions concerning patients' rights to be told risks, benefits, and possible alternatives in order to decide whether an intervention offered by a physician is acceptable. In the case of Natanson v. Kline in 1960, Mrs. Natanson underwent a mastectomy and subsequent cobalt treatments to deal with her breast cancer. Suffering severe burns and destruction of her ribs from radiation, she claimed negligence and failure to provide the pertinent information about this treatment. On appeal, the Kansas Supreme Court upheld the physician's obligation to explain to the patient in simple language the nature of the ailment, and possible risks and benefits of the proposed

treatment in comparison with alternatives. In 1972, the case of *Canterbury v. Spence*, in which the patient became paralyzed following a spinal surgery, came to a similar conclusion. However, in both cases, considerable leeway was accorded to the physicians in deciding what information is necessary for the patient to make an intelligent decision (Katz, 1984).

In 1973, the popular press reported two court cases involving breast cancer cases and the patients' right to self-determination. On June 8, a Pennsylvania judge decided that a 60-year-old woman who suffered from schizophrenia had a "right to die" rather than submit to surgery for "possible" breast cancer. This decision was not based on informed consent, but rather on the constitutional right of privacy, including the right to refuse a medical recommendation that may prolong life (A patient's 'right to die,' 1973).<sup>vi</sup> Conversely, in December a judge ruled that a sixty-five year old, mentally ill woman who suffered from breast cancer be forced to have a mastectomy in an attempt to save her life. Although informed consent was lacking, the judge determined this woman was not capable of choice (Fraser, 1973). Though both these cases were complicated by mental illness, the *opposing* decisions left readers to puzzle when patients' preferences affected medical decision-making, including enforced surgery. Earlier in this same year, the American Hospital Association approved the "Bill of Rights for Patients." One of those rights was that doctors must explain all options for treatment (Brody, 1973). Also advocating for the right to informed consent was the Health Research Group, headed by Ralph Nader, the nationally renowned consumer activist (Birth control use, 1972).

***The Women's Movement.*** In 1973, the tenth anniversary edition of Betty Friedan's landmark book, *The Feminine Mystique*, was published. In the original version, Friedan explained "the problem that has no name," her description of the lack of clear identity and self-esteem, and resulting feelings of unhappiness and incompleteness, widely experienced by the generation of women who came of age after World War II. Throughout the book, she discussed such notions (among many others) as the influence of



images in women's magazines and the incapacitating isolation that results from women not sharing their problems with one another. In this second edition, she added a chronicle of all the major events that had occurred since the initial publication, including her pivotal role in the formation of the National Organization for Women. In so doing, she celebrated the fledgling women's movement, the "second wave" of feminist activism. Many of the issues she emphasized would again come to the fore as the problems of breast cancer emerged more into public view. She concludes with this prophecy: "Women---the last and largest group of people in this nation to demand control of their own destiny---will change the very nature of political power in this country" (Friedan, 1973, p. 394).

Germaine Greer's work, *The Female Eunuch* (1970), contributed to a rising awareness of the female body as a literal and symbolic site of societal and personal struggle. Though hardly shocking in retrospect, her critical observations about the response to the female body had not been so explicitly stated previous to her writing. About women's bosoms she comments: "The degree of attention which breasts receive . . . makes women unduly anxious about them . . . Her breasts are only to be admired for as long as they show no sign of function" [to this last thought, we might also add the words "or dysfunction"] (Greer, 1971, p. 24).

Though Friedan's and Greer's books make no reference to breast cancer, the spirit of their work, in part, sparked the fledgling women's health movement which took hold in the early seventies. The first edition of the landmark self-health manual for women, *Our Bodies, Ourselves* (1973), contained a little over two pages on breast cancer.<sup>vii</sup> One of the main messages was an emphasis on the importance of early detection and regular self-examination. Other information included was reflective of the rudimentary state of knowledge about the disease and features statistics and admonishments not well publicized elsewhere; for example: "... in six out of every ten breast cancers . . . metastasis occurs within a *month* [sic] after the tumor is detected" (Boston Women's Health Book Collective, 1973, p. 263). In the section on treatments, the text explains that there are a



number of options, particularly in regard to surgery. Illustrated by a brief first-hand account, readers are strongly warned to exercise their rights to autonomy and informed consent: "Remember . . . that the doctor must have your permission for anything s/he does to you. If s/he refuses to consider alternative treatments or you do not feel that you can trust him or her, don't hesitate to change doctors" (p. 265).

However, the discourse of a re-awakened women's power, still in a relatively early stage, was the subject of much conflict and certainly had not been adapted by many women. Within breast cancer circles, Terese Lasser, founder of Reach-to-Recovery, was a prime example of a person who clearly wished to maintain the status quo in terms of how patients interacted with the medical system. After undergoing a radical mastectomy in 1952, Lasser started a highly innovative program to organize one-on-one in-hospital visits between new postoperative patients and women who had "successfully adapted" to that experience in order to provide advice and emotional support. This was one of the earliest ways in which women with breast cancer identified themselves to one another. The philosophy of the program was based on the concept of positive adjustment, appearing and feeling as though one's self-identity was unchanged, and distinct overtones of religious fervor (Lasser, 1972). In 1969, Reach-to-Recovery became part of the ACS and Lasser wrote a book documenting this program in 1972. Addressed to a readership of women with breast cancer, sample chapters include "You and the Man in Your Life" and "You and the Art of Grooming." Lasser included many practical tips on everyday living such as how to squeeze water out of a foam rubber breast form after coming out of a pool. In contrast to Friedan's encouragement of women to take control of their own lives, Lasser insisted Reach-to-Recovery visits had to be authorized by the patient's physician (though not by the patient herself). Though at quite a different level than the concerns of feminists, Lasser lent her voice to a newly emerging chorus of patients going public.

***Personal Narratives of Breast Cancer.*** First hand accounts of ordinary people's experiences with breast cancer slowly began to appear in popular periodicals, chiefly in

women's magazines, and later in newspapers. In several ways, these stories became counterparts to the scientific progress narratives with heroic male professionals featured in news magazines. In these narratives, women were depicted as combination heroine/victims, often providing graphic descriptions of radical mastectomies and other effects of treatment. There were relatively few published stories since it was still "iffy" to talk in public about having breast cancer. For instance, one such account that appeared in *Ebony* to help alert African Americans (Thompson, 9/72), was called "I was a Cancer Coward." The title, referring to the writer's reluctance to face up to a breast lump, has the tone of a dime-store confessional. Only one such publication was identified prior to 1970. This article was written by George Crile (1966), a breast surgeon about to become a pivotal figure in a public controversy, and was a testimonial to his dead wife. Interestingly, he never used the word "cancer," but referred instead to a "breast turnout" that spread. Many of these stories were about the drama of finding a lump, confirming a diagnosis of malignancy, having a mastectomy, then finding new meaning in a postoperative life (e.g., Byrd, 1970). Some were written by husbands, describing their own fear and discomfort in adjusting to a post-mastectomy marital relationship (Lobsenz, 1973; Piller, 1973). Generally, the stories featured younger women under the age of 50. Doctors were referred to with respect, awe, and gratitude, such as the woman who extolled, "How godlike he is. How completely the patient is in the doctor's hands" (Little, 1973). In general, the personal nature of these stories invited empathy, identification, fear (that this could happen to you), and hope (that women with breast cancer can resume fairly normal lives). However, it seems questionable that the positive effects on readers necessarily outweighed the negative. One horrifying example was a ten page cover story in the Sunday *Chicago Tribune Magazine* (Photopoulos, 1973), perhaps reflecting the increasing public interest in this subject. "My Fight Against Cancer," according to the author, was written to give courage to others. She proceeded to describe her experience with two mastectomies, an oophorectomy (removal of her ovaries), extensive radiation with cobalt,

and diminished quality of life. The story included an interesting description of "informed consent"; that is, while the patient was anesthetized for an incisional biopsy, the surgeons went out to the waiting room to ask her husband if it was permissible to remove her breast, if a frozen section analysis proved positive. Despite all this, she labeled herself as lucky. This patient was exercising voice, but not necessarily one of empowerment. It seems difficult to believe that the strongest impact of this article on readers would not have been to frighten them about the specter that they, too, might contract breast cancer in the future.

### **The Breast Surgery Controversy: The Rhetoric of Choice**

In 1970, several articles from surgeons appeared in women's magazines that raised the issue of doing more conservative surgical treatments such as simple mastectomy and lumpectomy (Cope, 1970; Shanahan, 1970) in lieu of radical mastectomy<sup>viii</sup>, in effect, these physicians wished to communicate this message directly to women. Even *Reader's Digest* picked up on the brewing controversy of which treatment to use (Maisel, 1971). An essay by Nolan (1971) also addressed the matter of including patients in decision-making. He asserted that surgeons are not sure which surgery is best; thus: "It's her breast and her life; she has a right to know" (p. 52).

The influence of Nolan's article became evident a few months later when a newly defiant personal narrative by Rosamond Campion appeared in *McCall's* (1972), entitled "The Right to Choose: One Woman's Revolt Against 50 Years of Medical Tradition." Campion, a feature writer, related how she was told by doctors at Sloan Kettering Memorial Hospital in New York, to have a radical mastectomy, after having a lump biopsied. After reading an advance copy of Nolan's article, she decided to find a doctor who would talk to her about doing a lumpectomy, instead. As the protagonist of this narrative, she connected herself with the women's movement, rebelling against paternalistic practitioners and stated, "I think what I did was the highest level of liberation"<sup>ix</sup> (p. 158).

Though Campion might have been perceived as a bit off-beat, the same theme reappeared a year later, when the world-famous Shirley Temple Black told her story of breast cancer to other women (Caplan, 1973). Like Campion, Black insisted on having a biopsy prior to and separate from any other surgery, and when her tumor proved malignant, she chose to have a simple mastectomy. Much of her article emphasized the importance of early detection, but she also mentioned having read Nolan's article and her own strong determination to participate in determining the kind of treatment she would have: "The ultimate decision is mine . . . the doctor can make the *incision*, but I'll make the *decision*" (p. 114).

Campion's surgeon turned out to be the same George Crile, who had earlier written about his wife's illness. He practiced for decades at the Cleveland Clinic, where no more than 1% of patients had undergone radical mastectomies since 1957. Though he and his colleagues had been collecting data about outcomes with more breast conserving surgeries for several years, he waited until 1973 (after his retirement so he could not be accused of an ethical breach of creating publicity in order to lure patients to his practice) to publish his book, *What Women Should Know About the Breast Cancer Controversy*. Indeed, by this time the issue of whether radical surgery was unnecessary had become a public controversy and Crile's work, which was excerpted in newspapers and magazines (Crile, 1973a, b, c, d) was in large part responsible for fanning the flames. Crile states that his purpose in writing for the public was to educate women that they may have a choice among less mutilating surgeries, depending on the size and location of the tumor, but that radical mastectomy---the most mutilating kind of surgery---was not necessary in terms of its success with cure and survival rates. His belief that fear of this treatment was endangering women's lives---insofar as they avoided diagnosis and/or surgery---more than the fear of the disease itself.

Crile's most vocal opponent regarding more conservative surgery and women's involvement in decision-making was well-known surgeon Jerome Urban from Sloan

Kettering Memorial Hospital in New York, the hospital at which Rosamond Campion had been unable to receive a lumpectomy. Urban's response to Crile's ideology was vividly articulated in an interview published in *Esquire* (Nobile, 1973):

The trouble with Crile is that he advocates so many god damn different things. . . . He has introduced a sense of chaos into breast treatment. Now any surgeon can do anything he pleases. . . . What American operating rooms need . . . is a straight law-and-order ticket. It's a *free* country unfortunately. Too free. It would be very nice if we had some sort of Academy of Medicine like they do in Russia to set the rules.<sup>x</sup>

The controversy over breast surgery and patient participation initiated by Crile received extensive media coverage including a one hour and forty minute discussion on the *David Susskind Show* that included Crile, Campion, Urban, and Lasser among others. Though Urban was his most prominent critic, Crile's credibility was also undermined by others, who tended to characterize him as an outlier at odds with the preponderance of experts in the field (e.g., *What you should know*, 1974), never mentioning his well-established record of publication in respected medical journals such as the *American Journal of Surgery*, *Cancer*, and *The Lancet*. One physician argued that Crile was "imposing on patients the burden of decisions they are unequipped to make" (Zimmerman, 1974, p. 22). In a similar vein, a journalist commented, "I admire Mrs. [Shirley Temple] Black tremendously, but I am sure that once I placed my body into the hands of the most competent of surgeons, I would find myself leaving both the decisions and the incision up to him or her" (Cole, p. 11). *Time* (1974) characterized the conflict as more ideological rather clinical, stating that "women's liberationists" . . . "see it [radical mastectomy] as a deliberate mutilation performed by male doctors who can neither understand nor appreciate its impact on their female patients" (p. 108). In sum, the rhetoric of choice in the context of breast cancer treatment was launched during the early seventies and given

broad public exposure, but was strongly resisted by a vocal portion of the professional community.

### **Betty and Happy: The Drama of the Decade**

Despite the publicity allotted to the conflict between Crile and his mainstream medical colleagues, the pivotal public event of the decade in reference to breast cancer was the macro-drama of the nation's First Lady, Betty Ford, and the Second Lady, Happy Rockefeller, both discovering breast malignancies within one month of one another, beginning in September, 1974.

In the case of Betty Ford, a breast lump was detected by her personal physician during a routine check-up. Two days later she underwent a traditional radical mastectomy. As she later recounted the situation for women readers, her surgeon discouraged consideration of lesser surgery: "He told me the biopsy had been positive and they had to perform a radical mastectomy. I just said, 'Yes sir, that's fine'" (Ford & Shelton, 1975, p. 142). Ironically, while Mrs. Ford was in the Naval Hospital in Bethesda, Maryland undergoing this procedure, a meeting of the nation's breast cancer experts were meeting across the street in order to review the results of the preliminary study of the national breast cancer task force, sponsored by the National Institutes of Health and headed by Dr. Bernard Fisher of the University of Pittsburgh. Fisher's research demonstrated no difference in recurrence or survival rates between patients who had undergone simple mastectomies with those who had undergone radicals. This study was one of the earliest in an ambitious series of investigations directed by Fisher under the rubric of the National Surgical Adjuvant Breast and Bowel Project (NSABP), comparing breast cancer treatments in an extensive and well controlled manner over the next two decades.<sup>xi</sup> Nonetheless, these initial results confirmed Criles' less rigorously derived conclusions.

Mrs. Ford's diagnosis and treatment received international news coverage, raising awareness about the importance of early detection. The public's response was extensive

and nearly immediate. In addition to overwhelming support and concern for the First Lady, appointments for mammograms were soon backed up (Brody, 1974; Barney, 1974). One of the thousands of American women who followed Betty Ford's example was Happy Rockefeller, the wife of the Vice President. In an amazing coincidence, she, too, had a lump detected upon examination, and in less than a month following Betty Ford's operation, Mrs. Rockefeller underwent a modified radical mastectomy performed by Dr. Jerome Urban.

As with the Ford story, media coverage of Happy Rockefeller's surgery was intense, yet hopeful. Following her operation, it was reported that her physicians predicted her chances for ten-year survival were excellent, at around 90% (Mrs. Rockefeller 'fine,' 1974; Andelman, 1974; Newsweek, 1974). Yet only four weeks later, Mrs. Rockefeller was again hospitalized in order to undergo a second mastectomy on her remaining breast. It was later revealed in newspaper stories that Dr. Urban had biopsied the second breast while his patient was under anesthesia for the first operation. From this sample, he found "pinhead" malignant cells. Vice President Rockefeller asked the doctors to say nothing to Mrs. Rockefeller or the public about this second occurrence until she had an opportunity to recover somewhat from the first procedure (Happy faces 2d surgery, 1974; Altman, 1974). While this delay in disclosure is understandable, it also raises a number of questions about how decisions regarding treatment of breast cancer were dealt with at the time. For example, though Dr. Urban routinely would perform a biopsy in the remaining breast, it is unclear from the media accounts (e.g., Rockefeller & Robb, 1975) that Mrs. Rockefeller's consent for this extra procedure had been sought. Also mystifying is why such a specifically optimistic prognosis had been released to the public when the medical team and her husband were aware of more serious problems. And finally, in light of the new studies acknowledged by a consensus panel of experts, showing the efficacy of less mutilating surgery, were alternatives to a second modified radical procedure discussed with the patient herself?



The national dramas of Betty Ford and Happy Rockefeller probably did more to focus attention on the issue of the prevalence of breast cancer among American women than any other events or stories occurring up to that time. People who may have unintentionally missed or consciously avoided previous media reports on the subject would have been hard-put to overlook the front page headline coverage of these two events. Mrs. Ford, in particular, received well-deserved praise for her courage and candor in sharing details of her illness narrative openly with the American public (Courage vs. cancer, 1974; Two courageous women, 1974; Howard, 1974). The results of the diagnoses of the First and Second Ladies were widespread discussions of issues attendant to breast cancer, vastly increased awareness, and thousands of women acting on this awareness by going to get mammograms. Without a doubt, it was a turning point in destigmatizing the disease itself and communication about it.

At the same time, it must be noted that against the background of the breast surgery controversy that had evolved over the previous four years and the expert consensus based on the NSABP study comparing radical and simple mastectomies, it is ironic that these two prominent women—women who ostensibly would have been the recipients of the best and most up-to-date medical care available—served as role models of passively compliant patients who let their physicians make all the treatment decisions and apparently refrained from considering known alternatives. The health education delivered to American women as a result of this public drama was, indeed, a mixed one.

### **A Final Word**

Despite the passive demeanor exemplified by Betty Ford and Happy Rockefeller, the decade of 1965-75 ended with the emergence of a less well recognized figure, but one who was to exert considerable influence on behalf of people with breast cancer regarding standard medical practices. Rose Kushner was a Washington, D.C.-based investigative reporter who herself survived an initial bout of breast cancer shortly after the Betty Ford event. The experience helped to turn her into an indefatigable activist and writer on the



subject.<sup>xiii</sup> Her first book published the next year (Kushner, 1975) begins with her personal experience of cancer but develops into a sophisticated explanation and exploration of issues related to breast cancer research and treatment. Receiving a significant amount of media exposure, Kushner became the first full-blown survivor-turned-lay authority, one who conferred with medical experts and encouraged other women to become knowledgeable about this disease and options available for them to consider. Said Kushner of her activist work: "I have no awe of doctors. I know how to use medical libraries and I know how to question" (Kleiman, 1975, 3:2). Her stance was a harbinger of events to come in the next decade.

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## Endnotes

<sup>i</sup> This statement does not imply there was no breast cancer discourse in the lay literature. Reagan (1997) discusses widespread cancer education efforts directed toward woman during the first half of the twentieth century in the form of materials distributed through the American Cancer Society and in the periodical lay press. She states that "in the 1950s, cancer education literature encouraged women to perform monthly breast self-examinations." Nonetheless, popular press articles about breast cancer in the mid to late 1960s are comparatively infrequent and brief.

<sup>ii</sup> A separate category for "breast cancer" did not exist until 1975.

<sup>iii</sup> This review included 128 magazine articles identified through the *Reader's Guide to Periodical Literature* and 202 newspaper articles identified through the *Index to the New York Times* and the *Index to the Chicago Tribune* (the *Tribune* index only begins in 1972). Magazines were grouped as news (e.g., *Newsweek*, *Time*, *U.S. News and World Report*) and women's (e.g., *Ladies Home Journal*, *McCall's*, *Mademoiselle*, *Ms.*). A third category referred to as miscellaneous comprised a combination of general interest (e.g., *Saturday Evening Post*, *Reader's Digest*) and specially targeted (e.g., *Esquire*, *The Nation*, *Ebony*, *Science Digest*) publications not included in the previous two classifications.

<sup>iv</sup> To this day, the war-on-cancer metaphor is widely in use. For example, Dr. V. Craig Jordan, the developer of the drug tamoxifen, recently shown to help prevent breast cancer in women at high risk, described the initial comparison of his drug with traditional chemotherapy treatment in this way: "Chemotherapy was the way to go then. Vigorous blasting of cancer. By comparison, tamoxifen was the silent killer of cancer cells, the stealth bomber, if you will" (Manier, 1998).

<sup>v</sup> These cases were *Pratt v. Davis* in 1905 and *Schoendorff v. The Society of New York Hospital* in 1914.

<sup>vi</sup> It is interesting to note that the same right to privacy was the legal basis in deciding *Roe v. Wade*, in which abortion became legalized the previous year.

<sup>vii</sup> By the publication of the second edition of *Our Bodies, Ourselves* in 1976, the section on "Breast Problems" had expanded to seven pages (pp. 125-131), in large part due to reader demand for more information (pp. 13-14).

<sup>viii</sup> The Halsted radical mastectomy, which had been considered standard-of-care treatment since the latter part of the nineteenth century includes removal of the breast, the underlying muscles of the chest wall, all glands in the armpit, as well as all the glands

beneath the muscles of the chest wall. This procedure leaves a lengthy scar, a deep indenture in the chest cavity, and at least 20% probability of swelling and disability of the arm. The modified radical which began to replace the standard radical in the early 1970's involves removal of the breast and a large sampling of lymph glands in the armpit. Another surgical option was the simple mastectomy which is comprised of the total removal of the breast only. A fourth option is lumpectomy or partial mastectomy involving surgical excision of the tumor and surrounding tissue, typically resulting in only a small scar.

<sup>ix</sup> This article was quickly published as a book, *The Invisible Rose* (1972).

<sup>x</sup> Urban's rhetoric is reflective of the law-and-order mentality that evolved during the Nixon Administration in response to civil disorder and a rising domestic crime rate, as well as Cold War imagery pertaining to totalitarian Communism. His melding of the two kinds of metaphors is an ironic conflation of American and Soviet references, curiously applied to the medical context.

<sup>xi</sup> The NSABP is a government funded series of clinical trials begun in 1957 to evaluate a variety of cancer treatments.

<sup>xii</sup> Kushner almost single-handedly lobbied to stop the practice of surgeons performing the mastectomy at the same time as the biopsy for, she reasoned, if the cancer has already spread, there is no point going through with a mastectomy (Kushner, 1975). The result of her efforts was the adoption of a two-step procedure, so that a woman would have the opportunity to absorb the confirmation of a cancer diagnosis and think through and discuss her treatment options, before consenting to a mastectomy or some other form of surgery.